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Supplemental Medicaid Payments for Eligible Professional Services
2. Roswell Park Cancer Institute: Payment up to the Average Commercial Rate

(a) Effective April 1, 2011, supplemental payments will be made to Roswell Park Cancer Institute Clinical Practice Plan providers for services eligible under this provision ("Eligible Services"). Supplemental payments for Eligible Services will be equal to the difference between the Average Commercial Rate, as defined below, and Medicaid payments otherwise made under this state plan. The supplemental payment will only be applicable to the professional component of the services provided. However, supplemental fee payments will not be available for services provided at facilities participating in the Medicare Teaching Election Amendment.

(b) Roswell Park Eligible Medical Professional Providers are :

(1) Physicians, Nurse Practitioners and Physician Assistants; who are

(2) Employed by a public benefit corporation, or a non-state operated public general hospital operated by a public benefit corporation or who are providing professional services at a public benefit corporation facility as either a member of a practice plan or an employee of a professional corporation or limited liability corporation under contract to provide services to patients of such a public benefit corporation for those patients eligible for Medicaid; and are

(3) Licensed by the State of New York.

Excluded providers are federally qualified health centers (FQHCs) and rural health centers (RHCs).

(c) Eligible Services include only those services provided by a Roswell Park Eligible Medical Professional Provider while acting in their capacity as a participant in a plan for the management of the clinical practice at Roswell Park.

(d) Services excluded are those utilizing procedure codes not reimbursed by Medicaid, clinical laboratory services, dual eligibles except where Medicaid becomes the primary payer, and Managed Care. Managed Care data will be included only when a separate fee for service payment has been made to an eligible provider. Non commercial payers such as Medicare are excluded. Additionally, supplemental payment will not be allowed on all inclusive payments where the base payment includes the physician cost.

(e) Supplemental payments will be made as an annual aggregate lump sum payment, based on the Medicaid data applicable to dates of service in the calendar year. Initial payments will be based on claims processed within 3 months after the calendar year for those dates of service. A final payment will be made one year following the initial payment to capture those claims for the payment year date of service processed subsequent to the initial payment. Supplemental payments will not be made prior to the delivery of services.

(f) Calculating the Average Commercial Rate (ACR) For Matched Procedures.

(1) The ACR will be calculated for Roswell based on applicable rates for the appropriate region, utilizing the top 5 commercial payers based on volume.

(2) The ACR will be calculated annually before each state fiscal year using commercial payer data from the most recently completed twelve month period by Date of Service between July and June. The initial calculation, effective beginning April 1, 2011, will be based on commercial payer data from the period of July 1, 2010, through June 30, 2011 Date of Service.

(3) For Eligible Service procedures (additionally distinguished by modifier and point of service) that are billed to Medicaid using codes that correspond to those recognized by commercial payers ("Matched Procedures"), a Procedure-Specific ACR will be calculated for each Matched Procedure by dividing the sum of total commercial payments for the Matched Procedure by the total number of the Matched Procedures paid by commercial payers. For services where physician extenders may be used the applicable percentage of the ACR will be applied.

(g) Calculating ACR for Non-Matched Procedures

(1) For Eligible Service procedures that are billed to Medicaid using codes that do not correspond to those recognized by commercial payers ("Non-Matched Procedures"), a Procedure-Specific ACR will be calculated for each Non-Matched Procedure by calculating the overall average percentage of the matched procedures commercial payments to Medicaid payments.

(2) This percentage is applied to the average Medicaid payments per unit for the non matched services to establish an ACR proxy payment per unit. The units for each non matched Medicaid service is multiplied by the ACR proxy, and then totaled to determine the payment ceiling.

(3) The difference between the total Medicaid payments for the unmatched services and the ACR proxy total is the supplemental payment for unmatched services.

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(h) Determining the Supplemental Payment Amount

(1) For each Eligible Service procedure, the Procedure-Specific Ceiling Amount is the product of the Procedure-Specific ACR and the number of times the procedure was paid by Medicaid to Eligible Medical Professional Providers The sum of all Procedure-Specific Ceiling Amounts for all Eligible Service procedures is the Supplemental Payment Ceiling.

(2) The Supplemental Payment Amount is calculated by subtracting total Medicaid payments made for Eligible Services from the Supplemental Payment Ceiling.

ACR Calculation Example

Example 1.
Calculation of Average Percentage of Commercial Payments to Medicaid Payments

CPT	Fee Code	Medicaid Volume	Medicaid Payments	ACR	ACR Medicaid Volume
99201	Facility	9	$ 98.33	$ 37.56	$ 338.02
99201	Non-Facility	29	$659.46	$ 48.16	$1,396.50
99202	Facility	67	$1,451.31	$ 72.65	$4,867.86
99202	Non-Facility	68	$2,533.87	$ 83.34	$5,667.20
99203	Facility	255	$8,491.44	$110.72	$28,234.48
99203	Non-Facility	154	$8,590.88	$123.25	$18,980.55
99204	Facility	157	$8,822.54	$179.74	$28,218.70
99204	Non-Facility	115	$9,570.55	$184.33	$21,197.88
99205	Facility	63	$4,485.55	$234.13	$14,750.23
99205	Non-Facility	38	$3,805.95	$237.02	$9,006.72
	Total Fees		**$ 48,509.88**		**$ 132,658.13**
Average percentage of Commercial Payments to Medicaid Payments					**273%**

Example 2:
Calculation of Payment Ceiling for Non Matched Codes and Total Supplemental Payment

CPT	Fee Code	Medicaid Volume	Medicaid Payments	Average Medicaid Payment	Comm. % of Medicaid	Calculated ACR Proxy	Calculated Payment Ceiling
59514	Facility	2	$1,791.02	$895.51	273%	$2,448.92	$4,897.83
59840	Facility	8	$1,840.00	$230.00	273%	$628.97	$5,031.78
27600	Facility	2	$202.40	$101.20	273%	$276.75	$553.50
92014	Non-Facility	118	$6,537.35	$55.40	273%	$151.50	$17,877.44
51728	Non-Facility	10	$1,509.94	$150.99	273%	$412.92	$4,129.18
	Totals		**$11,880.71**		**Payment Ceiling**		**$32,489.73**
					Supplemental Payment		**$20,609.02**

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(i) Agreed Upon Procedures Requirement for ACR and supplemental payment calculation

(1) An independent accountant must conduct an Agreed Upon Procedures engagement to evaluate the ACR and supplemental payment calculations. Each plan may choose its own independent accountant, but the actual core Agreed Upon Procedures to be conducted must be presented to the State for approval. In order to evaluate the ACR and supplemental calculation, the following minimum core procedures are to be conducted by the independent accountants:

a. Validate if the Average Commercial Rate fee schedule utilized in the calculation is appropriate for the time period of the calculation.

b. Select a random sample of at least 40 procedure codes with the highest amount of total payments to verify the mathematical accuracy of the calculation.

c. Validate that only eligible providers are present in the calculation as described under this provision.

The independent accountants will design techniques that will enable them to render an "Independent Accountant's Report on Applying Agreed-Upon Procedures" to the practice plan for the State.